Part 10: Service Definitions and Requirements

Sections 10.1 – 10.30

Section 10.22: Recreational Therapy

Section 10.23: Rent and Food for Unrelated Caregiver

Section 10.24: Residential Habilitation and Support ***(Revised as of 9/1/2012)***

Section 10.25: Respite ***(Updated as of 9/1/2012)***

Section 10.26: Specialized Medical Equipment and Supplies

Section 10.27: Speech/Language Therapy

*********NOTE: Structured Family Caregiving appears under Section 10.33 below***

Section 10.28: Supported Employment Follow Along (SEFA)

Section 10.29A: Transportation – as specified in the Family Supports Waiver ***(Revised as of 9/1/2012)***

Section 10.29B: Transportation - as specified in the Community Integration and Habilitation Waiver ***(Revised as of 9/1/2012)***

Section 10.30: Workplace Assistance

Section 10.31: Case Management ***(New as of 9/1/2012)***

Section 10.32: Participant Assistance and Care ***(New as of 9/1/2012)***

Section 10.33: Structured Family Caregiving ***(Replaced Adult Foster Care as of 9/1/2012)***

Section 10.1: Service Definition Overview

This section of the manual lists service definitions for the services currently approved for the Home and Community Based Services (HCBS) waiver programs operated by the Division of Disability and Rehabilitative Services. Each service definition includes the following information:

- A definition of the service.
- A list of reimbursable (allowable) activities for the service.
- Service standards
- Documentation standards
- Limitations
- A list of activities not allowed
- And in some cases, additional information or clarifications that are unique to the service
- Note that some services are not available under both waivers. Please refer to **Sections 4.5 and 4.6** and of this manual for the lists of available waiver services unique to each waiver.
- A chart containing procedure (billing) codes and modifiers as well as unit rates is found in Section 10.2.

Section 10.2: Service Rates

Medicaid Waiver Services, Codes, and Rates

[for Community Integration and Habilitation (CIH) Waiver and Family Supports (FSW) Waiver]

Waiver Type			INsite		Natl.	Modifiers					Unit/	Unit/$
	CIH	FSW	Code	Service Description	Code	1	2	3	4	Rate	Size	Limit
	■	■	ADS1	Adult Day Services, Level 1	S5101	U7	U5	U1		$21.95	.50/Day	2 Units/ Day
	■	■	ASD2	Adult Day Services, Level 2	S5101	U7	U5	U2		$28.80	.50/Day	2 Units/ Day
	■	■	ASD3	Adult Day Services, Level 3	S5101	U7	U5	U3		$34.29	.50/Day	2 Units/ Day
	■	■	AS14	Adult Day Services, ¼ Hour, Level 1	S5100	U7	U5	U1		$1.38	.25/Day	12 Units/Day
	■	■	AS24	Adult Day Services, ¼ Hour, Level 2	S5100	U7	U5	U2		$1.80	.25/Day	12 Units/Day
	■	■	AS34	Adult Day Services, ¼ Hour, Level 3	S5100	U7	U5	U3		$2.14	.25/Day	12 Units/Day
	■	■	BMGO	Behavior Management, Basic	H0004	U7	U5	U2		$18.20	.25/Hour	
	■	■	BG1O	Behavior Management, Level 1	H0004	U7	U5	U1		$18.20	.25/Hour	
	■	■	CMGT	Case Management	T2022	U7	U5			$125.00	1.00/Mnth	1 Unit/Month
	■	■	CHG2	Community Habilitation, Group (2:1)	T2020	U7	U5	U2		$8.48	1.00/Hour	
	■	■	CHG3	Community Habilitation, Group (3:1)	T2020	U7	U5	U3		$8.48	1.00/Hour	
	■	■	CHG4	Community Habilitation, Group (4:1)	T2020	U7	U5	U4		$8.48	1.00/Hour	
	■	■	CHG6	Community Habilitation, Group (6:1)	T2020	U7	U5	U6		$4.72	1.00/Hour	
	■	■	CHG8	Community Habilitation, Group (8:1)	T2020	U7	U5	U8		$4.72	1.00/Hour	
	■	■	CHGB	Community Habilitation, Group (10:1)	T2020	U7	U5	UB		$4.72	1.00/Hour	
	■	■	CHIO	Community Habilitation, Individual	T2020	U7	U5			$22.09	1.00/Hour	
	■		CT	Community Transition	T2038	U7	U5			Individual	1.00/Unit	$1,000 Lifetime
	■		EM1	Electronic Monitoring, 1 Participant	A9279	U7	U5	UA		$13.62	1.00/Hour	
	■		EM2	Electronic Monitoring, 2 Participants	A9279	U7	U5	U2		$6.81	1.00/Hour	
	■		EM3	Electronic Monitoring, 3 Participants	A9279	U7	U5	U3		$4.54	1.00/Hour	
	■		EM4	Electronic Monitoring, 4 Participants	A9279	U7	U5	U4		$3.41	1.00/Hour	
	■		EMOI	Environmental Modification (Install)	S5165	U7	U5	NU		Individual	1.00/Unit	$15,000 Lifetime
	■		EMOM	Environmental Modification (Maintain)	S5165	U7	U5	U8		Individual	1.00/Unit	$500/Year
	■	■	INSP	Equipment – Assess/Inspect/Train	T1028	U7	U5			$17.99	.25/Hour	
	■	■	FBS	Facility Based Support	T1020	U7	U5	UA		$1.85	1.00/Hour	
	■	■	FHG2	Facility Habilitation, Group (2:1)	T2020	U7	U5	UA	U2	$8.48	1.00/Hour	
	■	■	FHG4	Facility Habilitation, Group (4:1)	T2020	U7	U5	UA	U4	$8.48	1.00/Hour	
	■	■	FHG6	Facility Habilitation, Group (6:1)	T2020	U7	U5	UA	U6	$4.72	1.00/Hour	
	■	■	FHG8	Facility Habilitation, Group (8:1)	T2020	U7	U5	UA	U8	$4.72	1.00/Hour	
	■	■	FHGB	Facility Habilitation, Group (10:1)	T2020	U7	U5	UA	UB	$4.72	1.00/Hour	
	■	■	FHGC	Facility Habilitation, Group (12:1)	T2020	U7	U5	UA	UC	$3.00	1.00/Hour	
	■	■	FHGD	Facility Habilitation, Group (14:1)	T2020	U7	U5	UA	UD	$3.00	1.00/Hour	
	■	■	FHG9	Facility Habilitation, Group (16:1)	T2020	U7	U5	UA	U9	$3.00	1.00/Hour	
	■	■	FHIO	Facility Habilitation, Individual	T2020	U7	U5	UA		$22.09	1.00/Hour	
	■	■	FCAR	Family & Caregiver Training, Family	S5111	U7	U5			Individual	1.00/Unit	$2,000/Year
	■	■	FCNF	Family & Caregiver Training, Non-Family	S5116	U7	U5			Individual	1.00/Unit	$2,000/Year
	■	■	IBI1	Intensive Behavioral Intervention, Lvl 1	H2020	U7	U5	U1		$104.60	1.00/Hour	

	■	■	IBI2	Intensive Behavioral Intervention, Lvl 2	H2020	U7	U5	U2		$25.00	1.00/Hour	
	■	■	MUTH	Music Therapy	H2032	U7	U5	U1		$10.78	.25/Hour	
	■	■	OCTH	Occupational Therapy	G0152	U7	U5	UA		$17.99	.25/Hour	
		■	PAC	Participant Assistance and Care	T2033	U7	U5			$23.24	1.00/Hour	
	■	■	PRSI	Personal Response System, Install	S5160	U7	U5			$52.07	1.00/Unit	2 Units/CCB
	■	■	PRSM	Personal Response System, Maintain	S5161	U7	U5			$52.07	1.00	1 Unit/Month

Waiver Type		INsite		Natl.	Modifiers					Unit/	Unit/$
CIH	FSW	Code	Service Description	Code	1	2	3	4	Rate	Size	Limit
	■	■	PHTH	Physical Therapy	G0151	U7	U5	UA		$18.12	.25/Hour	
	■	■	PV02	Pre-Vocational (2:1)	T2015	U7	U5	U2		$8.48	1.00/Hour	
	■	■	PV04	Pre-Vocational (4:1)	T2015	U7	U5	U4		$8.48	1.00/Hour	
	■	■	PV06	Pre-Vocational(6:1)	T2015	U7	U5	U6		$4.72	1.00/Hour	
	■	■	PVO8	Pre-Vocational (8:1)	T2015	U7	U5	UA		$4.72	1.00/Hour	
	■	■	PV10	Pre-Vocational (10:1)	T2015	U7	U5	UB		$4.72	1.00/Hour	
	■	■	PV12	Pre-Vocational (12:1)	T2015	U7	U5	UC		$3.00	1.00/Hour	
	■	■	PV14	Pre-Vocational (14:1)	T2015	U7	U5	UD		$3.00	1.00/Hour	
	■	■	PV16	Pre-Vocational (16:1)	T2015	U7	U5	U9		$3.00	1.00/Hour	
	■	■	PSTF	Psychological Therapy, Family	90846	U7	U5			$17.27	.25/Hour	
	■	■	PSTG	Psychological Therapy, Group	90853	U7	U5			$4.81	.25/Hour	
	■	■	PSTI	Psychological Therapy, Individual	90832	U7	U5			$15.45	.25/Hour	
	■	■	RETH	Recreational Therapy	H2032	U7	U5	U2		$10.78	.25/Hour	
	■		R&F	Rent & Food for Unrelated Live-In Caregiver	T2025	U7	U5			$545.00	1.00/ Month	
	■		RH1O	Residential Habilitation Services, Lvl 1 (Less than 35 hrs/week)	T2016	U7	U5	UA		$23.24	1.00/Hour	
	■		RH2O	Residential Habilitation Services, Lvl 2 (Over 35 hrs/week)	T2016	U7	U5			$19.52	1.00/Hour	
	■	■	RNUR	Respite Nursing Care, RN	T1005	U7	U5	TD		$7.79	.25/Hour	
	■	■	RNUR	Respite Nursing Care, LPN	T1005	U7	U5	TE		$5.91	.25/Hour	
	■	■	RSPO	Respite Care Services	S5151	U7	U5			$23.24	1.00/Hour	
	■		ATCH	Specialized Medical Equip/Supply, Install	T2029	U7	U5	NU		Individual	1.00/Unit	
		■	ATCH	Specialized Medical Equip/Supply, Install	T2029	U7	U5	NU		Individual	1.00/Unit	$7,500 Lifetime
	■	■	ATCM	Specialized Medical Equip/Supply, Maintain	T2029	U7	U5	U8		Individual	1.00/Unit	$500/Year
	■	■	SPTH	Speech Therapy	92507	U7	U5	UA		$18.12	.25/Hour	
	■		AF01	Structured Family Caregiving, Level 1	S5140	U7	U5	U1		$51.87	1.00/Day	1 Unit/Day
	■		AF02	Structured Family Caregiving, Level 2	S5140	U7	U5	U2		$75.67	1.00/Day	1 Unit/Day
	■		AF03	Structured Family Caregiving, Level 3	S5140	U7	U5	U3		$102.87	1.00/Day	1 Unit/Day
	■	■	SF1O	Supported Employment Tier 1 (Monthly 1-5 hours)	T2018	U7	U5	U1		$175.95	1.00/ Month	
	■	■	SF2O	Supported Employment Tier 2 (Monthly 6-10 hours)	T2018	U7	U5	U2		$351.90	1.00/ Month	
	■	■	SF3O	Supported Employment Tier 3 (Monthly 11-15 hours)	T2018	U7	U5	U3		$527.85	1.00/ Month	

	■	■	SF4O	Supported Employment Tier 4 (Hourly)	T2018	U7	U5			$35.19	1.00/Hour	
		■	TRNO	Transportation	T2002	U7	U5			$5.00	1.00/Trip	2 Trips/Day
	■		TRNO	Transportation, Level 1	T2002	U7	U5			$5.00	1.00/Trip	2 Trips/Day,$2500 /Year
	■		TRN2	Transportation, Level 2	T2002	U7	U5	U2		$20.00	1.00/Trip	2 Trips/Day,$5000 /Year
	■		TRN3	Transportation, Level 3	T2002	U7	U5	U3		$40.00	1.00/Trip	2 Trips/Day,$7500 /Year
	■		VMOD	Vehicle Modification, Install	T2039	U7	U5			Individual	1.00/Unit	$15,000 Lifetime
		■	VMOD	Vehicle Modification, Install	T2039	U7	U5			Individual	1.00/Unit	$7,500 Lifetime
	■	■	VMOM	Vehicle Modification, Maintain	T2039	U7	U5	U8		Individual	1.00/Unit	$500/Year
	■	■	WPA	Workplace Assistance	T1020	U7	U5			$26.37	1.00/Hour	

Section 10.3: Adult Day Services

Adult Day Services

Service Definition

Adult Day Services are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, and therapeutic activities, supervision, support services, and personal care. Meals and/or nutritious snacks are required. The meals need not constitute the full daily nutritional regimen. However, each meal must meet 1/3 of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting in one of three available levels of service; Basic, Enhanced or Intensive.

Reimbursable Activities

- Adult Day Services may be used in conjunction with Transportation Services.

Basic Adult Day (Level 1) includes:

- Monitor and/or supervise all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed.
- Comprehensive, therapeutic activities.
- Health assessment and intermittent monitoring of health status.
- Monitor medication or medication administration.
- Appropriate structure and supervision for those with mild cognitive impairment.
- Minimum staff ratio: One staff for each eight individuals.

Enhanced Adult Day Services (Level 2) includes Level 1 service requirements must be met. Additional services include:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care.
- Health assessment with regular monitoring or intervention with health status.
- Dispense or supervise the dispensing of medication to individuals.
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers.

- Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments.
- Minimum staff ratio: One staff for each six individuals.

Intensive Adult Day Services (Level 3) includes Level 1 and Level 2 service requirements must be met. Additional services include:

- Hands-on assistance or supervision with all ADLs and personal care.
- One or more direct health intervention(s) required.
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available.
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care.
- Therapeutic interventions for those with moderate to severe cognitive impairments.
- Minimum staff ratio: One staff for each four individuals.

Service Standards

Adult Day Services must follow a written plan of care addressing specific needs determined by the individual's assessment.

Documentation Standards

- Services outlined in the Individualized Support Plan (ISP)
- Evidence that level of service provided is required by the individual
- Attendance record documenting the date of service and the number of units of service delivered that day
- Completed Adult Day Service Level of Service Evaluation form

The case manager should give the completed Adult Day Service Level of Service Evaluation form to the provider.

Limitations

- Individuals attend Adult Day Services on a planned basis. A minimum of three (3) hours to a maximum of 12 hours shall be allowable.

- A single half-day (1/2 day) day unit is defined as one unit of three (3) hours to a maximum of five (5) hours/day. Two units are defined as more than five (5) hours to a maximum of 8 hours/day. A maximum of two half-day (1/2 day) units/day is allowed.
- A single quarter-hour (1/4 hour) unit is defined as 15 minutes. Billable only after 8 hours of ADS have been provided on the same day. A maximum of 16 quarter-hour (1/4 hour) units/day is allowed.

Activities Not Allowed

Any activity that is not described in allowable activities is not included in this service.

PROVIDER QUALIFICATIONS

- Be enrolled as an active Medicaid provider
- Must be DDRS Approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual
- Must be accredited by at least one (1) of the following organizations:
    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

Section 10.4: *was* ***Adult Foster Care- Now see Section 10.27.5: Structured Family Caregiving***

Section 10.5: Behavioral Support Services

Behavioral Support Services

Service Definition

Behavioral Support Services means training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

Reimbursable Activities

Reimbursable activities of Behavioral Support Services include:

- Observation of the individual and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions
- Obtain consensus of the Individualized Support Team that the behavioral support plan is feasible for implementation.
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan
- Consultation with team members

Service Standards

- Behavioral Support Services must be reflected in the Individualized Support Plan (ISP)
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan.
- The behavior supports specialist will observe the individual in his or her own milieu and develop a specific plan to address identified issues.
- The behavior supports specialist must assure that Residential Habilitation and Supports direct service staff are aware of and are active individuals in the development and

implementation of the Behavioral Support Plan. The behavior plan will meet the requirements stated in the DDRS' Behavioral Support Plan Policy.

- The behavior supports provider will comply with all specific standards in 460 IAC 6.
- Any behavior supports techniques that limit the individual's human or civil rights must be approved by the Individualized Support Team (IST) and the provider's human rights committee. No aversive techniques may be used. Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with caution. The use of these medications must be approved by the Individualized Support Team (IST) and the appropriate human rights committee.
- The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary.
- The behavior specialist will provide a written report to pertinent parties at least quarterly. Pertinent parties include the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other involved entities.

Documentation Standards

- Services outlined in the Individualized Support Plan (ISP)
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

Activities Not Allowed

- Aversive techniques – Any techniques not approved by the individual's person centered planning team and the provider's human rights committee.
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day.
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian.
- Services furnished to a participant by the participant's spouse.
- In the event that a Level 1 clinician performs Level 2 clinician activities, billing for Level 1 services is not allowed. In this situation, billing for Level 2 services only is allowed.
- Simultaneous receipt of facility-based support services or other Medicaid-billable services and intensive behavior supports.

PROVIDER QUALIFICATIONS

- Be enrolled as an active Medicaid provider
- Must be DDRS Approved
- Must comply with Indiana Administrative Code, 460 IAC 6

- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual

Additional Information:

- Waiver funded Behavioral Support Services may not be utilized when the consumer is residing in an institution
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

Section 10.6: Community Based Habilitation – Group

Community Based Habilitation – Group

Service Definition

Community Based Habilitation - Group are services provided outside of the Participant's home that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Community based activities are intended to build relationships and natural supports.

- Community settings are defined as non-residential, integrated settings that are primarily out in the community where services are not rendered within the same building(s) alongside other non-integrated participants

Reimbursable Activities

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

- Leisure activities and community/public events (i.e. integrated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (i.e. volunteer opportunities)
- Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

- Develop self advocacy skills
- Exercise civil rights
- Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards

- Community Based Habilitation Services must be reflected in the Individualized Support Plan (ISP).
- Services must address needs identified in the person centered planning process and be outlined in the ISP.

Documentation Standards

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry.
- Electronic signatures are permissible when in compliance with the Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

- **For Group services**
- Upon request, the provider must be able to verify the following in a concise format:

- the ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream

Limitations

Group Sizes:

- Small groups (4:1 or smaller)
- Medium groups (5:1 to 10:1)

Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a community event.

Activities Not Allowed

- Services that are available under the Rehabilitation Act of 1973 or PL 94-142.
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome. Activities that do not foster the acquisition and retention of skills.
- Services furnished to a minor by parent(s), step parents(s) or legal guardian.
- Services furnished to a participant by the participant's spouse.
- Services rendered in a facility.
- Group size in excess of 10:1.

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.
- Must be accredited by at least one (1) of the following organizations:

    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.

4) The National Committee for Quality Assurance, or its successor.

5) The ISO-9001 human services QA system.

6) An independent national accreditation organization approved by the secretary

Additional Information:

- Activities must have a habilitation component
- Community Based Habilitation – Group services are available under the Family Supports Waiver and the Community Integration and Habilitation Waiver

Section 10.7: Community Based Habilitation – Individual

Community Based Habilitation - Individual

Service Definition

Community Based Habilitation - Individual are services provided outside of the Participant's home that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Community based activities are intended to build relationships and natural supports.

Community settings are defined as non-residential, integrated settings that are primarily out in the community where services are not rendered within the same building(s) alongside other non-integrated participants Reimbursable Activities

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

- Leisure activities and community/public events (i.e. integrated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (i.e. volunteer opportunities)
- Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

- Develop self advocacy skills
- Exercise civil rights
- Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards

- Community Based Habilitation Services must be reflected in the Individualized Support Plan (ISP).

- Services must address needs identified in the person centered planning process and be outlined in the ISP.

Documentation Standards

- Services outlined in the Individualized Support Plan
- Need for service continuation and justification of goals is to be evaluated annually and reflected in the ISP

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry.
- Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

Limitations

Allowable Ratio - 1:1

Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a community event.

Activities Not Allowed

- Services that are available under the Rehabilitation Act of 1973 or PL 94-142.
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome
- Activities that do not foster the acquisition and retention of skills.
- Services furnished to a minor by parent(s), step parents(s) or legal guardian.
- Services furnished to a participant by the participant's spouse.
- Services rendered in a facility.

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.
- Must be accredited by at least one (1) of the following organizations:

    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Activities must have a habilitation component.
- Community Based Habilitation – Individual services are available under the Family Supports Waiver and the Community Integration and Habilitation Waiver

Section 10.8: Community Transition

Community Transition

Service Definition

Community Transition Services include reasonable, one-time set-up expenses for individuals who make the transition from an institution to their own home in the community and will not be reimbursable on any subsequent move.

> Note: Own Home is defined as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the individual and/ or the individual's guardian or family, or a home that is owned and/ or operated by the agency providing supports.

Items purchased through Community Transition Services are the property of the individual receiving the service, and the individual takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition Services because those services are part of the per diem.

Reimbursable Activities

- Security deposits that are required to obtain a lease on an apartment or home.
- Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, window coverings, eating utensils, food preparation items, bed or bath linens
- Set-up fees or deposits for utility or service access including telephone, electricity, heating, and water
- Health and safety assurances including pest eradication, allergen control, or one time cleaning prior to occupancy
- When the individual is receiving residential habilitation and support services under the CIH, the Community Transition Supports service is included in the Cost Comparison Budget

Service Standards

- Community Transition services must be reflected in the Individualized Support Plan (ISP) and Cost Comparison Budget (CCB) of the individual.
- Services must address needs identified in the ISP and CCB.

Documentation Standards

Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered.

Limitations

Community Transition Services are limited to one time set-up expenses, up to $1,000.

Activities Not Allowed

- Apartment or housing rental expenses
- Food
- Appliances
- Diversional or recreational items such as hobby supplies
- Television
- Cable TV access
- VCRs or DVD players

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available only under the Community Integration and Habilitation Waiver. Community Transition services are not available under the Family Supports Waiver.

Section 10.9: Electronic Monitoring

Electronic Monitoring

Service Definition

Electronic Monitoring/Surveillance System & On-Site Response includes the provision of oversight and monitoring within the residential setting of adult waiver participants through off-site electronic surveillance. Also included is the provision of stand-by intervention staff prepared for prompt engagement with the participant(s) and/or immediate deployment to the residential setting.

Reimbursable Activities

- Electronic Monitoring/Surveillance System & On-Site Response may be installed in residential settings in which all residing adult participants, their guardians and their support teams request such surveillance and monitoring in place of on-site staffing.
- Use of the system may be restricted to certain hours through the Individualized Support Plans of the participants involved.

Service Standards

To be reimbursed for operating an electronic monitoring and surveillance system, a provider must adhere to the following:

- The system to be installed must be reviewed and approved by Director of DDRS.
- The Electronic Monitoring/Surveillance System & On-Site Response system must be designed and implemented to ensure the health and welfare of the participant in his/her own home/apartment and achieve this outcome in a cost neutral manner.
- The case manager and/or the BDDS Service Coordinator will review the use of the system at seven (7) days, and again at fourteen (14) days post installation.
- Services provided to waiver participants or otherwise reimbursed by the Medicaid program is subject to oversight/approval from the OMPP.
- Retention of written documentation is required for seven (7) years
- Retention of video/audio records, including computer vision, audio and sensor information, shall be retained for seven (7) years if an Incident Report is filed.

Assessment and informed consent

- Initial assessment: Participants requesting this service must be preliminarily assessed by the Individualized Support Team (IST) for appropriateness in ensuring the health and welfare of the participants and have written approval by the human rights committee (HRC). These actions must be documented in the ISP and the DDRS case management system.
- Informed consent: Each participant, guardian and IST must be made aware of both the benefits and risks of the operating parameters and limitations. Informed consent documents must be acknowledged in writing, signed and dated by the participant, guardian, case manager, and provider agency representative, as appropriate. A copy of the consent shall be maintained by the local BDDS office, the guardian (if applicable) and in the home file.
- Annual assessment updates: At least annually, the IST must assess and determine that continued usage of the electronic monitoring system will ensure the health and welfare of the participant. The results of this assessment must be documented in the ISP and in the DDRS case management system. A review of all incident reports and other relevant documentation must be part of this assessment.

System design

- The provider must have safeguards and/or backup system such as battery and generator for the electronic devices in place at the monitoring base and the participant's residential living site(s) in the event of electrical outages.
- The provider must have backup procedures for system failure (e.g., prolonged power outage), fire or weather emergency, participant medical issue or personal emergency in place and detailed in writing for each site utilizing the system as well as in each participant's ISP. This plan should specify the staff person or persons to be contacted by monitoring base staff who will be responsible for responding to these situations and traveling to the participant's living site(s).
- The electronic monitoring system must receive notification of smoke/heat alarm activation at each participant's residential living site.
- The electronic monitoring system must have two way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of participants in each living site, including emergency situations when the participant may not be able to use the telephone.
- The electronic monitoring system must allow the monitoring base staff to have visual (video) oversight of areas in participant's residential living sites deemed necessary by the IST.
- A monitoring base may not be located in a participant's residential living site.

- A secure (HIPAA compliant) network system requiring authentication, authorization and encryption of data must be in place to ensure access to computer vision, audio, sensor or written information is limited to authorized staff including the parent/guardian, provider agency, Family and Social Services Administration (FSSA), DDRS, BDDS, Bureau of Quality Improvement Services (BQIS), Qualified Mental Retardation Professional, case manager, and participant.
- The equipment must include a visual indicator to the participant that the system is on and operating.

Situations involving electronic monitoring of participants needing 24 hour support. If a participant indicates that he/she wants the electronic monitoring system to be turned off, the following protocol will be implemented:

1) The electronic caregiver will notify the provider to request an on-site staff.
2) The system would be left operating until the on-site staff arrives.
3) The electronic caregiver would turn off the system at that site once relieved by an on-site staff.
4) A visible light on the control box would signal when the system is on and when it is off.

Monitoring base staff

- At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of participants at remote living sites.
- The monitoring base staff will assess any urgent situation at a participant's residential living site and call 911 emergency personnel first if that is deemed necessary, and then call the float staff person. The monitoring base staff will stay engaged with the participant(s) at the living site during an urgent situation until the float staff or emergency personnel arrive.
- If computer vision or video is used, oversight of a participant's home must be done in real time by an awake-staff at a remote location (monitoring base) using telecommunications/broadband, the equivalent or better, connection.
- The monitoring base (remote station) shall maintain a file on each participant in each home monitored that includes a current photograph of each participant which must be updated if significant physical changes occur and at least, annually. The file shall also include pertinent information on each participant noting facts that would aid in ensuring the participants' safety.
- The monitoring base staff must have detailed and current written protocols for responding to needs of each participant at each remote living site, including contact information for staff to supply on-site support at the participant's residential living site when necessary.

Stand-by intervention staff (float staff)

- The float staff shall respond and be at the participant's residential living site within 20 minutes or less from the time the incident is identified by the remote staff and float staff acknowledges receipt of the notification by the monitoring base staff. The IST Team has the authority to set a shorter response time based on individual participant need.
- The service must be provided by one (1) float staff for on-site response, the number of participants served by the one (1) float staff is to be determined by the Individualized Support Team (IST) based upon the assessed needs of the participants being served in specifically identified locations.
- Float staff will assist the participant in the home as needed to ensure the urgent need/issue that generated a response has been resolved. Relief of float staff, if necessary, must be provided by the residential habilitation provider.

Documentation Standards

- Services outlined in the Individualized Support Plan (ISP)

To be reimbursed, the provider must prepare and be able to produce the following:

- Status as a DDRS/BDDS approved provider
- Approval of the specific electronic monitoring/surveillance system by the Director of DDRS.
- Case notes regarding the assessment and approval by both the IST of each participant and the HRC will be documented within both the DDRS system and the ISP.
- Informed consent documents must be acknowledged in writing, signed and dated by the participant, guardian, case manager, and provider agency representative, as appropriate. Copies of consent documents will be maintained by the local BDDS office, the case manager, the guardian (if applicable) and in the home file.
- Utilization of the electronic monitoring device must be outlined in the ISPs, service planners and budgets of EACH participant in a setting, including typical hours of electronic monitoring

Each remote site will have a written policy and procedure approved by DDRS (and available to OMPP for all providers serving waiver participants) that defines emergency situations and details how remote and float staff will respond to each. Examples include:

- Fire, medical crises, stranger in the home, violence between participants, and any other situation that appears to threaten the health or welfare of the participant.

- Emergency Response drills must be carried out once per quarter per shift in each home equipped with and capable of utilizing the electronic monitoring service. Documentation of the drills must be available for review upon request.
- The remote monitoring base staff shall generate a written report on each participant served in each participant's residential living site on a daily basis. This report will follow documentation standards of the Residential Habilitation Services. This report must be transmitted to the primary RHS provider daily.
- Each time an emergency response is generated, an incident report must be submitted to the State per the BDDS and BQIS procedures.
- At least every 90 days, the appropriateness of continued use of the monitoring system must be reviewed by the IST; the results of these reviews must be documented in the DDRS case management system and/or the ISP. Areas to be reviewed include but are not limited to the number and nature of responses to the home as well as damage to the equipment.

Limitations and Reimbursement Parameters

The budget will be completed for each participant based upon the number of participants residing within the residence.

Reimbursement Rates by Tier

Tier	Number of Participants	Reimbursement
Tier 1	1 Participant in a home	$13.62
Tier 2	2 Participants in a home	$ 6.81
Tier 3	3 Participants in a home	$4.54
Tier 4	4 Participants in a home	$3.41

Activities Not Allowed

- Electronic monitoring and surveillance systems which have not received specific approval by the Director of the Division of Disability and Rehabilitative Services (DDRS).
- Electronic Monitoring may not be used concurrently with Structured Family Caregiving services or in the Structured Family Caregiving home
- Electronic Monitoring systems intended to monitor direct care staff

- Electronic Monitoring serves as a replacement for Residential Habilitation and Support (RHS) services, therefore, Electronic Monitoring and RHS services are not billable during the same time period
- Electronic Monitoring systems in ICF/ID facilities licensed under IC 16-28 and 410 IAC 16.2
- Electronic Monitoring systems used in place of in-home staff to monitor minors, i.e., participants under the age of 18.
- Installation costs related to video and/or audio equipment
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
- Services furnished to a participant by the participant's spouse

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
  Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available only under the Community Integration and Habilitation Waiver. Electronic Monitoring is <u>not</u> available under the Family Supports Waiver.

Section 10.10: Environmental Modifications

Environmental Modifications

Service Definition

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Waiver Services must approve all environmental modifications prior to service being rendered.

Reimbursable Activities

- Installation of ramps and grab bars
- Widening doorways
- Modifying existing bathroom facilities
- Installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual including anti-scald devices
- Maintenance and repair of the items and modifications installed during the initial request
- Assessment and inspection

Service Standards

- Equipment and supplies must be for the direct medical or remedial benefit of the individual
- All items shall meet applicable standards of manufacture, design and installation
- To ensure that environmental modifications meet the needs of the individual and abide by established, federal, state, local and FSSA standards, as well as ADA requirements, approved environmental modifications will reimburse for necessary:
    - Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications

    - Independent inspections during the modification process and at completion of the modifications, prior to authorization for reimbursement, based on the complexities of the requested modifications.
- Equipment and supplies shall be reflected in the Individualized Support Plan
- Equipment and supplies must address needs identified in the person centered planning process

Documentation Standards

- Identified direct medical benefit for the individual
- Documented "Prior Authorization Denial" from Medicaid, if applicable
- Receipts for purchases
- Identified need in Individualized Support Plan
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

- Reimbursement for Environmental Modification Supports has a lifetime cap of $15,000.
- Service and repair up to $500 per year, outside this cap, is permitted for maintenance and repair of prior modifications that were funded by a waiver service.
- If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.

Activities Not Allowed

- Adaptations to the home which are of general utility
- Adaptations which are not of direct medical or remedial benefit to the individual (such as carpeting, roof repair, central air conditioning)
- Adaptations which add to the total square footage of the home
- Adaptations that are not included in the comprehensive plan of care
- Adaptations that have not been approved on a Request for Approval to Authorize Services

- Adaptations to service provider owned/leased housing. Home accessibility modifications as a service under the waiver may not be furnished to individuals who receive residential habilitation and support services except when such services are furnished in the participant's own home.

- Compensation for the costs of life safety code modifications and other accessibility modifications may not be made with participant waiver funds to housing owned by providers.

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

- Must hold current professional licensure/certification as appropriate

Additional Information:

- Available only under the Community Integration and Habilitation Waiver. Environmental Modifications are <u>not</u> available under the Family Supports Waiver.
- Photographs of the proposed areas to be modified must be provided.
- The Environmental Modification policy appears in **Part 11: RFA Policies, Section 11.1: Environmental Modification Policy** of this manual.

Section 10.11: Facility Based Habilitation – Group

Facility Based Habilitation - Group

Service Definition

Facility Based Habilitation services are services provided outside of the Participant's home in an approved facility that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills.

- Facility settings are defined as non-residential, non-integrated settings that take place within the same building(s) for the duration of the service rather than being out in the community

Reimbursable Activities

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

- Leisure activities (i.e. segregated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (i.e. volunteer opportunities)
- Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

- Develop self advocacy skills
- Exercise civil rights
- Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards

- Facility Based Habilitation Services must be reflected in the Individualized Support Plan (ISP).

- Services must address needs identified in the person centered planning process and be outlined in the ISP.

Documentation Standards

- Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

- **For Group services**

- Upon request, the provider must be able to verify the following in a concise format. The ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream.

Limitations

Group sizes:

- Small (4:1 or smaller)
- Medium (5:1 to 10:1)
- Larger (larger than 10:1 but no larger than 16:1)

Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a community event.

Activities Not Allowed

- Services that are available under the Rehabilitation Act of 1973 or PL 94-142.
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome
- Activities that do not foster the acquisition and retention of skills.
- Activities that would normally be a component of a person's residential life or services, such as: shopping, banking, household errands, medical appointments, etc.
- Services furnished to a minor by parent(s) or step parents(s) or legal guardian.
- Services furnished to a participant by the participant's spouse.

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.
- Must be accredited by at least one (1) of the following organizations:

    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.

5) The ISO-9001 human services QA system.

6) An independent national accreditation organization approved by the secretary

Additional Information:

- Activities must have a habilitation component
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver

Section 10.12: Facility Based Habilitation – Individual

Facility Based Habilitation - Individual

Service Definition

Facility Based Habilitation - Individual are services provided outside of the participant's home in an approved facility that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills.

- Facility settings are defined as non-residential, non-integrated settings that take place within the same building(s) for the duration of the service rather than being out in the community

Reimbursable Activities

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

- Leisure activities (i.e. segregated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (i.e. volunteer opportunities)
- Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

- Develop self advocacy skills
- Exercise civil rights
- Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards

- Facility Based Habilitation - Individual services must be reflected in the ISP

- Services must address needs identified in the person centered planning process and be outlined in the ISP

Documentation Standards

- Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

Limitations

Allowable Ratio - 1:1

- Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a camp

Activities Not Allowed

- Services that are available under the Rehabilitation Act of 1973 or PL 94-142
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome
- Activities that do not foster the acquisition and retention of skills
- Services furnished to a minor by parent(s) or step parents(s), or legal guardian
- Services furnished to a participant by the participant's spouse

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.
- Must be accredited by at least one (1) of the following organizations:

    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Activities must have a habilitation component
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waivers

Section 10.13: Facility Based Support Services

Facility Based Support Services

Service Definition

Facility Based Support services are facility-based group programs designed to meet the needs of participants with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, therapeutic activities, supervision, support services, personal care and may also include optional or non-work related educational and life skill opportunities. Participants attend on a planned basis.

> Facility settings are defined as non-residential, non-integrated settings that take place within the same building(s) for the duration of the service rather than being out in the community

Reimbursable Activities

- Monitor and/or supervise activities of daily living (ADLs) defined as dressing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
- Appropriate structure, supervision and intervention
- Minimum staff ratio: 1 staff for each 16 participants
- Medication administration
- Optional or non-work related educational and life skill opportunities (such as how to use computers/computer programs/Internet, set an alarm clock, write a check, fill out a bank deposit slip, plant and care for vegetable/flower garden, etc. may be offered and pursued

Service Standards

- Facility Based Support services must be reflected in the Individualized Support Plan
- Facility Based Support services must follow a written Plan of Care addressing specific needs as identified in the Individualized Support Plan

Documentation Standards

- Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

For Group Services

- Upon request, the provider must be able to verify the following in a concise format the ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream

Limitations

- These services must be provided in a congregate, protective setting in groups not to exceed 16:1.
- Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual in a group is participating when they receive skills training, such as the cost to attend a community event.

Activities Not Allowed

- Any activity that is not described in allowable activities is not included in this service
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
- Services furnished to a participant by the participant's spouse
- Prevocational Services

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

Section 10.14: Family and Caregiver Training

Family and Caregiver Training

Service Definition

Family and Caregiver Training services provide training and education to:

- Instruct a parent, other family member, or primary caregiver about the treatment regimens and use of equipment specified in the Individualized Support Plan; and
- Improve the ability of the parent, family member or primary caregiver to provide the care to or for the individual.

Reimbursable Activities

- Treatment regimens and use of equipment
- Stress management
- Parenting
- Family dynamics
- Community integration
- Behavioral intervention strategies
- Mental health
- Caring for medically fragile individuals

Service Standards

- Family and Caregiver Training Services must be included in the Individualized Support Plan
- The Individualized Support Plan shall be based on the person centered planning process with that individual.

Documentation Standards

- Services outlined in the Individualized Support Plan
- Receipt of payment for activity
- Proof of participation in activity if payment is made directly to individual/family.

- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

Reimbursement for this service is limited to no more than $2,000/year

Activities Not Allowed

- Training/instruction not pertinent to the caregiver's ability to give care to the individual
- Training provided to caregivers who receive reimbursement for training costs within their Medicaid or state line item reimbursement rates
- Meals, accommodations, etc., while attending the training

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Family and Caregiver Training cannot be used to provide behavioral programs or supports or other direct services covered under other available State Plan or Waiver services.
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

Section 10.15: Intensive Behavioral Intervention

Intensive Behavioral Intervention

Service Definition

Intensive Behavioral Intervention (IBI) is a highly specialized, individualized program of instruction and behavioral intervention. IBI is based upon a functional, behavioral and/or skills assessment of an individual's treatment needs. The primary goal of IBI is to reduce behavioral excesses, such as tantrums and acting out behaviors, and to increase or teach replacement behaviors that have social value for the individual and increase access to their community. Program goals are accomplished by the application of research based interventions.

Generally, IBI addresses manifestations that are amenable to change in response to specific, carefully programmed, constructive interactions with the environment.

IBI must include:

- a detailed functional/behavioral assessment;
- reinforcement;
- specific and ongoing objective measurement of progress;
- Family training and involvement so that skills can be generalized and communication promoted;
- Emphasis on the acquisition, generalization and maintenance of new behaviors across other environments and other people;
- Training of caregivers, IBI direct care staff, and providers of other waiver services;
- Breaking down targeted skills into small, manageable and attainable steps for behavior change;
- Utilizing systematic instruction, comprehensible structure and high consistency in all areas of programming;
- Provision for one-on-one structured therapy;
- Treatment approach tailored to address the specific needs of the individual.

Skills training under IBI must include:

- measurable goals and objectives (specific targets may include appropriate social interaction, negative or problem behavior, communication skills, and/or language skills);

- Heavy emphasis on skills that are prerequisites to language (attention, cooperation, imitation).

Reimbursable Activities

- Preparation of an IBI support plan in accordance with the DDRS' Behavioral Support Plan Policy
- Application of a combination of the following empirically-based, multi-modal and multidisciplinary comprehensive treatment approaches:
    - Intensive Teaching Trials (ITT), also called Discrete Trial Training, is a highly specific and structured teaching approach that uses empirically validated behavior change procedures. This type of learning is instructor driven, and may use error correction procedures or reinforcement to maintain motivation and attention to task. ITT consists of the following:
        - Antecedent: a directive or request for the individual to perform an action;
        - Behavior: a response from the individual, including anything from successful performance, non-compliance, or no response;
        - Consequence: a reaction from the therapist, including a range of responses from strong positive reinforcement, faint praise, or a negative (not aversive) reaction; and
        - A pause to separate trials from each other (inter-trial interval).
    - Natural Environment Training (NET) is learner directed training in which the learner engages in activities that are naturally motivating and reinforcing to him or her, rather than the more contrived reinforcement employed in ITT.
    - Interventions that are supported by research in behavior analysis and which have been found to be effective in the treatment of individuals with intellectual/developmental disabilities which may include but are not limited to:
        - Precision teaching: A type of programmed instruction that focuses heavily on frequency as its main datum. It is a precise and systematic method of evaluating instructional tactics. The program emphasizes learner fluency and data analysis is regularly reviewed to determine fluency and learning.
        - Direct instruction: A general term for the explicit teaching of a skill-set. The learner is usually provided with some element of frontal instruction of a concept or skill lesson followed by specific instruction on identified skills. Learner progress is regularly assessed and data analyzed.

        - Pivotal response training: This training identifies certain behaviors that are "pivotal" (i.e., critical for learning other behaviors). The therapist focuses on these behaviors in order to change other behaviors that depend on them.
    - Errorless teaching or other prompting procedures that have been found to support successful intervention. These procedures focus on the prevention of errors or incorrect responses while also monitoring when to fade the prompts to allow the learner to demonstrate ongoing and successful completion of the desired activity.
    - Additional methods that occur and are empirically-based.
- Specific and ongoing objective measurement of progress, with success closely monitored via detailed data collection.

Service Standards

- An appropriate range of hours per week is generally between 20-30 hours of direct service. It is recommended that Intensive Behavioral Intervention Services be delivered a minimum of 20 hours per week. When fewer than 20 hours per week will be delivered, justification must be submitted explaining why the IST feels a number fewer than the recommended minimum is acceptable;
- A detailed IBI support plan is required.
- At least quarterly, the Individualized Support Team (IST) must meet to review the IBI, consider the need for change, develop a new plan, or set new goals;
- IBI Services must be reflected in the Individualized Support Plan;
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan;
- Services must be detailed in the IBI support plan;
- Services are usually direct and one-to-one, with the exception of time spent in training the caregiver(s) and the family; ongoing data collection and analysis; goal and plan revisions;
- The IBI Case Supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, IBI Director, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities;
- The IBI Director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, IBI Case Supervisor, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities.

Documentation Standards

- Services outlined in the Individualized Support Plan (ISP).
- Documentation in compliance with 460 IAC 6.
- The IBI Case Supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, IBI Director, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities.
- The IBI Director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, IBI Case Supervisor, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities.

Limitations

See activities not allowed

Activities Not Allowed

- Aversive techniques as referenced within 460 IAC 6
- Interventions that may reinforce negative behavior, such as "Gentle Teaching"
- Group activities
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
- Services furnished to a participant by the participant's spouse
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

Section 10.16: Music Therapy

Music Therapy

Service Definition

Music Therapy Services means services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition of nonmusical skills and behaviors.

Reimbursable Activities

- Therapy to improve:
  - Self-image and body awareness
  - Fine and gross motor skills
  - Auditory perception
- Therapy to increase:
  - Communication skills
  - Ability to use energy purposefully
  - Interaction with peers and others
  - Attending behavior
  - Independence and self-direction
- Therapy to reduce maladaptive (stereotypic, compulsive, self-abusive, assaultive, disruptive, perseverative, impulsive) behaviors.
- Therapy to enhance emotional expression and adjustment.
- Therapy to stimulate creativity and imagination. The music therapist may provide services directly or may demonstrate techniques to other service personnel or family members
- **Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant.**

Service Standards

- Music Therapy Services should be reflected in the Individualized Support Plan of the individual
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan. Services must complement other services the individual receives and enhance increasing health and safety for the individual

Documentation Standards

- Documentation of appropriate assessment by a qualified therapist
- Services outlined in Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care/therapy with the balance of the hour spent in related patient services.

Activities Not Allowed

- Any services that are reimbursable through the Medicaid State Plan.
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
- Specialized equipment needed for the provision of Music Therapy Services should be purchased under "Specialized Medical Equipment and Supplies Supports"
- Activities delivered in a nursing facility

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6

- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.
- Certified Music Therapist By a Certification Board for Music Therapists, that is Accredited by a National Commission for Certifying Agencies

Additional Information:

- The focus of this service must be therapeutic in nature rather than on the acquisition of musical skills obtained as the result of music lessons such as piano lessons, guitar lessons etc.
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

Section 10.17: Occupational Therapy

Occupational Therapy

Service Definition

Occupational Therapy Services means services provided by a licensed/certified occupational therapist.

Reimbursable Activities

- Evaluation and training services in the areas of gross and fine motor function, self-care and sensory and perceptual motor function.
- Screening
- Assessments
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant
- Direct therapeutic intervention
- Design, fabrication, training and assistance with adaptive aids and devices
- Consultation or demonstration of techniques with other service providers and family members

Service Standards

- Individual Occupational Therapy Services must be reflected in the Individualized Support Plan.
- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards

- Documentation by appropriate assessment by a qualified therapist
- Services outlined in the Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times

- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care/therapy with the balance of the hour spent in related patient services.

Activities Not Allowed

- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
- Activities delivered in a nursing facility
- Services that are available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.
- Must meet licensure and certification requirements of IC 25-23.5

Additional Information

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

***** Participant Assistance and Care (PAC)*** *services appear in* ***Section 10.32*** *below*

Section 10.18: Personal Emergency Response System

Personal Emergency Response System

Service Definition

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

Reimbursable Activities

- PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision.
- Device Installation service
- Ongoing monthly maintenance of device

Service Standards

Must be included in the Individualized Support Plan (ISP)

Documentation Standards

- Identified need in the Individualized Support Plan (ISP)
- Documentation of expense for installation
- Documentation of monthly rental fee

Limitations

See Activities Not Allowed

Activities Not Allowed

- Reimbursement is not available for Personal Emergency Response System Supports when the individual requires constant supervision to maintain health and safety.

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available under the Family Supports Waiver and the Community Integration and Habilitation. Waiver

Section 10.19: Physical Therapy

Physical Therapy

Service Definition

Physical Therapy Services means services provided by a licensed physical therapist

Reimbursable Activities

- Screening and assessment
- Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone, activities of daily living
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant
- Direct therapeutic intervention
- Training and assistance with adaptive aids and devices
- Consultation or demonstration of techniques with other service providers and family members

Service Standards

- Individual Physical Therapy Services must be reflected in the Individualized Support Plan.
- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards

Physical Therapy Services documentation must include:

- Documentation by appropriate assessment
- Services outlined in the Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs, and chart detailing service provided, date, and times.

- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

Limitations

One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services.

Activities Not Allowed

- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
- Activities delivered in a nursing facility
- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the waiver for this service)

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.
- Must meet licensure/certification criteria of IC 25-27-1

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

Section 10.20: Prevocational Services

Prevocational Services

Service Definition

Prevocational Services are services that prepare a participant for paid or unpaid employment.

Prevocational Services include teaching concepts such as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at generalized result. Services are habilitative in nature and not explicit employment objectives.

Reimbursable Activities

- Monitoring, training, education, demonstration, or support provided to assist with the acquisition and retention of skills in the following areas:
    - Paid and unpaid training compensated less than 50% federal minimum wage
    - Generalized and transferrable employment skills acquisition
- These activities may be provided using off-site enclave or mobile community work crew models.
- Participants may choose to utilize Supported Employment Follow Along (SEFA) services and Pre-Vocational Services during the same service plan year

Service Standards

- Pre-Vocational Services must be reflected in the Individualized Support Plan (ISP)
- All Pre-Vocational Services will be reflected in the participant's plan of care as directed to habilitative, rather than explicit employment objectives
- Participant is not expected to be able to join the general workforce or participate in sheltered employment within one year (excluding Supported Employment)

Documentation Standards

- Services outlined in the Individualized Support Plan
- In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:
    - Name of participant served

- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8)

- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

- *The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

- **For Group services**

Upon request, the provider must be able to verify the following in a concise format the ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream.

Limitations

Group sizes:

- Small (4:1 or smaller)
- Medium (5:1 to 10:1)
- Large (larger than 10:1 but no larger than 16:1)

Monitoring of prevocational services provision will be performed at a minimum every 6 months using the pre-vocational services monitoring tool administered by the state or their designee. The objectives of monitoring include assessment of the participant's progress toward achieving

the outcomes identified on the participant's ISP related to employment and to verify the continued need for prevocational services.

Activities Not Allowed

- Services that are available under the Rehabilitation Act of 1973 or section 602(16) & (17) of Individual with Disabilities Education Act
- Activities that do not foster the acquisition and retention of skills
- Services in which compensation is greater than 50% federal minimum wage
- Activities directed at teaching specific job skills
- Sheltered employment, facility or community based
- Services furnished to a minor by parent(s) or stepparents(s) or legal guardian

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.
- Must be accredited by at least one (1) of the following organizations:

    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.
- Facility settings are defined as non-residential, non-integrated settings that take place within the same building(s) for the duration of the service rather than being out in the community
- Community settings are defined as non-residential, integrated settings that are primarily out in the community where services are not rendered within the same building(s) alongside other non-integrated participants

Section 10.21: Psychological Therapy

Psychological Therapy

Service Definition

Psychological Therapy services means services provided by a licensed psychologist with an endorsement as a health service provider in psychology, a licensed marriage and family therapist, a licensed clinical social worker, or a licensed mental health counselor.

Reimbursable Activities

- Individual counseling
- Biofeedback
- Individual-centered therapy
- Cognitive behavioral therapy
- Psychiatric services
- Crisis counseling
- Family counseling
- Group counseling
- Substance abuse counseling and intervention
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant

Service Standards

- Therapy Services should be reflected in the Individualized Support Plan of the individual.
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
- Services must complement other services the individual receives and enhance increasing independence for the individual

Documentation Standards

- Documentation by appropriate assessment
- Services outlined in the Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

Limitations

One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services.

Activities Not Allowed

- Activities delivered in a nursing facility
- Services that are available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

Section 10.22: Recreational Therapy

Recreational Therapy

Service Definition

Recreational Therapy Services means services provided under this article and consisting of a medically approved recreational program to restore, remediate, or rehabilitate an individual in order to:

- Improve the individual's functioning and independence; and
- Reduce or eliminate the effects of an individual's disability.

Reimbursable Activities

- Organizing and directing Adapted sports, Dramatics, Arts and crafts, Social activities, and other recreation services designed to restore, remediate or rehabilitate
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant

Service Standards

- Recreational Therapy Services should be reflected in the Individualized Support Plan (ISP)
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan.
- Services must complement other services the individual receives and enhance increasing independence for the individual

Documentation Standards

- Documentation by appropriate assessment
- Services outlined in Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs, and/or chart detailing service provided, date, and times

- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

Limitations

Activities Not Allowed

- Payment for the cost of the recreational activities, registrations, memberships or admission fees associated with the activities being planned, organized or directed
- Any services that are reimbursable through the Medicaid State Plan
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
-

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

Section 10.23: Rent and Food for Unrelated Caregiver

Rent and Food for Unrelated Caregiver

Service Definition

Rent and Food for an Unrelated, Live-in Caregiver Supports means the additional cost a participant incurs for the room and board of an unrelated, live-in caregiver (who has no legal responsibility to support the participant) as provided for in the participant's Residential Budget.

Reimbursable Activities

- The individual participant receiving these services lives in his or her own home
- For payment to not be considered income for the participant receiving services, payment for the portion of the costs of rent and food attributable to an unrelated, live-in caregiver (who has no legal responsibility to support the participant) must be made directly to the live-in caregiver
- Room and board for the unrelated live-in caregiver (who is not receiving any other financial reimbursement for the provision of this service)
- Room: shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services
- Board: three meals a day or other full nutritional regimen
- Unrelated: unrelated by blood or marriage to any degree
- Caregiver: an individual providing a covered service as defined by BDDS service definitions or in a Medicaid HCBS waiver, to meet the physical, social or emotional needs of the participant receiving services

Service Standards

- Rent and Food for an Unrelated Live-in Caregiver should be reflected in the Individualized Support Plan (ISP)
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan

- Services must complement other services the participant receives and enhance increasing independence for the participant
- The person centered planning team will decide and assure that the individual who will serve as a live-in caregiver has the experience, skills, training and knowledge appropriate to the participant and the type of support needed

Documentation Standards

Rent and Food for Unrelated Live-in Caregiver documentation must include:

- Identified in the Individualized Support Plan
- Documentation of how amount of Rent and Food was determined
- Receipt that funds were paid to the live-in caregiver
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

Limitations

See Activities Not Allowed

Activities Not Allowed

- When the participant lives in the home of the caregiver or in a residence owned or leased by the provider of other services, including Medicaid waiver services
- When the live-in caregiver is related by blood or marriage (to any degree) to the participant and/or has any legal responsibility to support the participant

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Paid Caregivers are not eligible for this service
- Available only under the Community Integration and Habilitation Waiver. Rent and Food for Unrelated Caregivers is not available under the Family Supports Waiver.

Residential Habilitation and Support

Service Definition

Residential Habilitation and Support Services provide up to a full day (24-hour basis) of services and/or supports which are designed to ensure the health, safety and welfare of the participant, and assist in the acquisition, improvement, and retention of skills necessary to support participants to live successfully in their own homes.

Billable either as:

- RH1O - for Level 1 with 35 hours or less per week of RHS, OR
- RH2O - for Level 2 with greater than 35 hours per week of RHS

Reimbursable Activities

RHS includes the following activities:

- Direct supervision, monitoring and training to implement the Individualized Support Plan (ISP) outcomes for the participant through the following:
  - Assistance with personal care, meals, shopping, errands, chore and leisure activities and transportation (excluding transportation that is covered under the Medicaid State Plan)
  - Coordination and facilitation of medical and non-medical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, utilization of available supports in a cost effective manner and maintenance of each participant's health record
  - Assurance that direct service staff are aware and active individuals in the development and implementation of ISP, Behavior Support Plans and Risk Plans

Service Standards

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan (ISP)
- Residential Habilitation and Support services should complement but not duplicate habilitation services being provided in other settings
- Services provided must be consistent with the participant's service planner

Documentation Standards

- RHS documentation must include:
  - Services outlined in Individualized Support Plan
  - Data record of staff-to-consumer service documenting the complete date and time entry (including a.m. or p.m.) All staff members who provide uninterrupted,

continuous service in direct supervision or care of the participant must make one entry. If a staff member provides interrupted service (one hour in the morning and one hour in the evening), an entry for each unique encounter must be made. All entries should describe an issue or circumstance concerning the participant. The entry should include complete time and date of entry and at least the last name, first initial of the staff person making the entry

- If the person providing the service is required to be professionally licensed, the title of that individual must also be included. For example, if a nurse is required, the nurse's title should be documented.

- Any significant issues involving the participant requiring intervention by a Health Care Professional, Case Manager or BDDS staff member that involved the participant are also to be documented

- Monthly reporting summaries are required

- Documentation in compliance with 460 IAC 6

Limitations

Reimbursable waiver funded services furnished to a waiver participant by any combination of relative(s)* and/or legal guardian(s) may not exceed a total of 40 hours per week. (See Activities Not Allowed for definition of relative)

Additionally:

- Providers may not bill for RHS reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement. (A team may decide that a staff or contractor may sleep while with a participant, but this activity is not billable.)

- Providers may not bill for RHS reimbursement during the time when a participant is admitted to a hospital. (The care and support of a participant who is admitted to a hospital is a non-billable RHS activity.)

- RHS and Electronic Monitoring services are not billable during the same time period.

- Level 1 RHS may not exceed thirty-five (35) hours of service per week

Activities Not Allowed

Reimbursement is not available through RHS in the following circumstances:

- Services furnished to a **minor** by the parent(s), step-parent(s), or legal guardian

- Services furnished to a participant by the participant's spouse
- Services to individuals in Structured Family Caregiving services
- Services that are available under the Medicaid State Plan
- Reimbursable waiver funded services furnished to a waiver participant by any combination of relative(s)* and/or legal guardian(s) may not exceed a total of 40 hours per week.

* Related/relative implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:

1) Aunt (natural, step, adopted)
2) Brother (natural, step, half, adopted, in-law)
3) Child (natural, step, adopted)
4) First cousin (natural, step, adopted)
5) Grandchild (natural, step, adopted)
6) Grandparent (natural, step, adopted)
7) Nephew (natural, step, adopted)
8) Niece (natural, step, adopted)
9) Parent (natural, step, adopted, in-law)
10) Sister (natural, step, half, adopted, in-law)
11) Spouse (husband or wife)
12) Uncle (natural, step, adopted)

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

- Per House Enrolled Act 1360 (P.L.154-2012), Indiana Code [IC 12-11-1.1-1] is amended to state:
    - Beginning July 1, 2012, the bureau shall ensure that an entity approved to provide residential habilitation and support services under home and community based

services waivers is accredited by an approved national accrediting body. However, if an entity is accredited to provide home and community based services under subdivision (1) other than residential habilitation and support services, the bureau may extend the time that the entity has to comply with this subdivision until the earlier of the following:

- The completion of the entity's next scheduled accreditation survey.
- July 1, 2015.

o In accordance with the above citation from Indiana Code [IC 12-11-1.1-1], RHS providers must be accredited by at least one (1) of the following organizations:

- The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
- The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
- The National Committee for Quality Assurance, or its successor.
- The ISO-9001 human services QA system.
- The Council on Accreditation, or its successor.
- An independent national accreditation organization approved by the secretary.

Additional Information:

- Available only under the Community Integration and Habilitation Waiver. Residential Habilitation and Support is not available under the Family Supports Waiver.

Section 10.25: Respite

Respite

Service Definition

Respite Care services means services provided to participants unable to care for themselves that are furnished on a short-term basis in order to provide temporary relief to those unpaid persons normally providing care. Respite Care can be provided in the participant's home or place of residence, in the respite caregiver's home, in a camp setting, in a DDRS approved day habilitation facility, or in a non-private residential setting (such as a respite home).

Reimbursable Activities

- Assistance with toileting and feeding
- Assistance with daily living skills, including assistance with accessing the community and community activities
- Assistance with grooming and personal hygiene
- Meal preparation, serving and cleanup
- Administration of medications
- Supervision
- Individual services
- Group services (Unit rate divided by number of participants served)

Service Standards

- Respite care must be reflected in the Individualized Support Plan
- Respite Nursing Care (RN) or Respite Nursing Care (LPN) services may only be delivered when skilled care is required

Documentation Standards

Service Notes: A service note can include multiple discrete services as long as discrete services are clearly identified A service note must include:

- Participant name
- RID #

- Date of Service
- Provider rendering service
- Primary location of services rendered
- An activity summary for each block of time this service is rendered must exist and must include: duration, service, a brief description of activities, significant medical or behavioral incidents requiring intervention, or any other situation that is uncommon for the participant. A staff signature must be present for each block of time claimed on a service note. A new entry is not required unless a different discrete service is provided (i.e. one continuous note may exist even if the ratio changes)
- For Group Services upon request, the provider must be able to verify the following in a concise format the ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream
- Electronic signatures are acceptable if the provider has a log on file showing the staff member's electronic signature, actual signature and printed name

Limitations

Waiver funded Respite services may not be rendered in a nursing facility

Activities Not Allowed

- Reimbursement for room and board
- Services provided to an participant living in a licensed facility-based setting
- The cost of registration fees or the cost of recreational activities (for example, camp)
- When the service of Structured Family Caregiving is being furnished to the participant
- Other family members (such as siblings of the participant) may not receive care or supervision from the provider while Respite care is being provided/billed for the waiver participant(s)
- Respite care shall not be used as day/child care
- Respite is not intended to be provided on a continuous, long-term basis as part of daily services that would enable the unpaid caregiver to go to work or to attend school
- Respite care shall not be used to provide service to a participant while the participant is attending school

- Respite care may not be used to replace skilled nursing services that should be provided under the Medicaid State Plan
- Respite care must not duplicate any other service being provided under the participant's Plan of Care/Cost Comparison Budget (CCB)
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
- Services furnished to a participant by the participant's spouse

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.
- Respite may be used intermittently to cover those hours normally covered by an unpaid caregiver

Section 10.26: Specialized Medical Equipment and Supplies

Specialized Medical Equipment and Supplies

Service Definition

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live and without which the individual would require institutionalization.

Waiver Services must approve all specialized medical equipment and supplies prior to service being rendered.

Reimbursable Activities

- Items necessary for life support
- Adaptive equipment and supplies
- Ancillary supplies and equipment needed for the proper functioning of specialized medical equipment and supplies
- Durable medical equipment not available under Medicaid State Plan
- Non-durable medical equipment not available under Medicaid State Plan
- Vehicle Modifications
- Communications devices
- Interpreter services

Service Standards

- Equipment and supplies must be of direct medical or remedial benefit to the individual
- All items shall meet applicable standards of manufacture, design and installation
- Any individual item costing over $500 requires an evaluation by a qualified professional such as a physician, nurse, Occupational Therapist, Physical Therapist, Speech and Language Therapist or Rehabilitation Engineer
- Annual maintenance service is available and is limited to $500 per year. If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need.

Documentation Standards

- Identified need in Individualized Support Plan (ISP) and Plan of Care/Cost Comparison Budget (CCB).
- Identified direct medical benefit for the individual.
- Documentation of the request for IHCP prior approval (denied PA).
- Documentation of the reason of denial of IHCP prior authorization.
- Receipts for purchases.
- Signed and approved Request for Approval to Authorize Services (State Form 45750)

Limitations

Service and repair up to $500 per year is permitted for maintenance and repair of previously obtained specialized medical equipment that was funded by a waiver service. If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need.

A lifetime cap of $15,000 is available for vehicle modifications. In addition to the $15,000 lifetime cap, $500 will be allowable annually for repair, replacement, or an adjustment to an existing modification that has been provided through the HCBS waiver. If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.

Vehicle Modifications have a cap of $7,500 under the Family Supports Waiver, but a cumulative lifetime cap of $15,000 across all HCBS Waiver Programs operated by the State.Activities Not Allowed

- Equipment and services that are available under the Medicaid State Plan
- Equipment and services that are not of direct medical or remedial benefit to the individual
- Equipment and services that are not included in the comprehensive plan of care
- Equipment and services that have not been approved on a Request for Approval to Authorize services (RFA)
- Equipment and services that are not reflected in the Individualized Support Plan

- Equipment and services that do not address needs identified in the person centered planning process

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available under the Community Integration and Habilitation Waiver and the Family Supports Waiver.

Section 10.27: Speech/Language Therapy

Speech/Language Therapy

Service Definition

Speech-Language Therapy Services means services provided by a licensed speech pathologist under 460 IAC 6 Supported Living Services and Supports requirements.

Reimbursable Activities

- Screening
- Assessment
- Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids.
- Evaluation and training services to improve the ability to use verbal or non-verbal communication.
- Language stimulation and correction of defects in voice, articulation, rate and rhythm.
- Design, fabrication, training and assistance with adaptive aids and devices.
- Consultation demonstration of techniques with other service providers and family members.
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant

Service Standards

- Individual Speech-Language Therapy Services must be reflected in the Individualized Support Plan.
- To be eligible for this service, the individual must have been examined by a certified audiologist and/or a certified speech therapist who has recommended a formal speech/audiological program.
- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards

- Documentation of an appropriate assessment
- Services outlined in the Individualized Support Plan
- BDDS approved provider
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times.
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care/therapy with the balance of the hour spent in related patient services.

Activities Not Allowed

- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
- Activities delivered in a nursing facility

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

***** Structured Family Caregiving appears under Section 10:33 below***

Section 10.28: Supported Employment Follow Along (SEFA)

Supported Employment Follow Along

Service Definition

Supported Employment Follow Along services are services and supports (time-limited to 18 months per employment setting), that enable a participant who is paid at or above the federal minimum wage to maintain employment in a competitive community employment setting. The 18-month clock begins with the start date of the SEFA service as it appears on the approved Plan of Care/Cost Comparison Budget (CCB) and Notice of Action (NOA). Note that the 18-month clock does not begin with the date the service is first rendered or with the date the service is first billed for this time-limited service, unless those dates correspond to the start date of the service as it appears on the CCB and NOA.

In each of the following situations (job in jeopardy, career advancement or job loss, as described below) requests for exceptions for SEFA beyond the approved 18 months will be reviewed. While there is a suggested 18-month time limit, time can be extended when a CCB (plan of service) is submitted. Depending on each participant's circumstances, the time limit may need to be extended or the participant may need to be referred to, or back to, Vocational Rehabilitation for services and reimbursement, in which case, concurrent reimbursement for Supported Employment Follow-Along and Vocational Rehabilitation Services will not be allowed. Extensions are currently granted to anyone who is still making efforts toward employment.

- Definitions for job in jeopardy, career advancement or job loss:
    - Job in jeopardy – the participant will lose his/her job without additional intervention, or
    - Career advancement – it is determined that the new job requires more complex, comprehensive, intensive supports than can be offered under the waiver, or
    - Job loss, the participant may need to be referred to, or back to, Vocational Rehabilitation for services and reimbursement, in which case, concurrent reimbursement for Supported Employment Follow-Along and Vocational Rehabilitation Services will not be allowed

Reimbursable Activities

Unless an exception is granted by DDRS as described previously, reimbursement is not available under Supported Employment Follow Along services for more than 18 months per employment setting, with the 18-month clock starting with the service start date as it appears on the CCB and NOA.

Reimbursement is available through Supported Employment Follow-Along Services for the following activities:

- Time spent at the participant's work site: observation and supervision of the participant, teaching job tasks and monitoring at the work site a minimum of twice a month, to ascertain the success of the job placement
- At the request of the participant, off site monitoring may occur as long as the monitoring directly relates to maintaining a job
- Employment services occur in an integrated work setting
- The provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment
- Regular contact and/or follow-up with the employers, participants, parents, family members, guardians, advocates or authorized representatives of the participants, and other appropriate professional and informed advisors, in order to reinforce and stabilize the job placement
- Facilitation of natural supports at the work site
- Individual program development, writing tasks analyses, monthly reviews, termination reviews and behavioral intervention programs
- Advocating for the participant , but
    - only with persons at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment; **OR**
    - with persons not directly affiliated with the employment site (i.e., parents, bus drivers, case managers, school personnel, landlords, etc.) if the person is hired and currently working
- Staff time used in traveling to and from a work site
- Supports for up to 18 months per employment setting

- Participants may utilize Workplace Assistance in conjunction with SEFA
- Participants may also utilize Pre-Vocational Services in conjunction with SEFA

Service Standards

When Supported Employment services are provided at a worksite where persons without disabilities are employed, payment will only be made for the adaptation, supervision and training required by participants receiving waiver services as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business

setting Services are tailored to the needs and interests identified in the person centered planning process and must be outlined in the Individualized Support Plan (ISP)

Documentation Standards

- Supported Employment Follow Along services must be outlined in the Individualized Support Plan (ISP)

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

Limitations

- Allowable ratio: Individual, 1:1
- Unless an exception is granted by DDRS as described previously, reimbursement is not available under Supported Employment Follow Along services for more than 18 months

per employment setting, with the 18-month clock starting with the service start date as it appears on the CCB and NOA.

- A waiver participant who is unable to sustain competitive employment after 18 months of service/support is considered inappropriately placed and continuing funding is not available without movement to a better-fit employment setting or authorization of a DDRS-approved exception for special circumstances.
- As previously noted, while there is a suggested 18-month time limit, time can be extended when a CCB (plan of service) is submitted, and extensions are currently granted to anyone who is still making efforts toward employment. A formal appeal is not necessary to request this extension.

Activities Not Allowed

Reimbursement is not available under Supported Employment Follow Along services for the following activities:

- Transportation of an individual participant
- Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142
- Activities taking place in a group, i.e., work crews or enclaves
- Public relations
- Community education
- In-service meetings, department meetings, individual staff development
- Incentive payments made to an employer to subsidize the employer's participation in a supported employment program
- Payments that are passed through to users of supported employment programs
- Sheltered work observation
- Payments for vocational training that is not directly related to a participant's supported employment program
- Any other activities that are non-participant specific, i.e., the job coach is working the job instead of the participant
- Any activities which are not directly related to the participant's vocational plan
- Services furnished to a minor by a parent(s), step-parent(s) or legal guardian

- Services furnished to a participant by the participant's spouse

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.
- Must be accredited by at least one (1) of the following organizations:

    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Available under Family Supports Waiver and the Community Integration and Habilitation Waiver.
- Participants may also utilize Workplace Assistance during any hours of competitive employment in conjunction with their use of SEFA
- Participants may also utilize Pre-Vocational Services during the same plan year as SEFA
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.
- Facility settings are defined as non-residential, non-integrated settings that take place within the same building(s) for the duration of the service rather than being out in the community
- Community settings are defined as non-residential, integrated settings that are primarily out in the community where services are not rendered within the same building(s) alongside other non-integrated participants

Section 10.29A: Transportation (as specified in the Family Supports Waiver)

Transportation

Service Definition

Transportation Services under the Family Supports Waiver enable waiver participants to gain access to any non-medical community services, resources/destinations, or places of employment, maintain or improve their mobility within the community, increase independence and community participation and prevent institutionalization as specified by the Individualized Support Plan and plan of care.

Reimbursable Activities

- Two one-way trips per day to or from a non-medical community service, resource or place of employment as specified on the ISP and provided by an approved provider of Residential Habilitation and Support, Community Based Habilitation, Facility Based Habilitation, Adult Day Services or Transportation Services.
- Bus passes or alternate methods of transportation may be utilized
- May be used in conjunction with other services, including Community Based Habilitation, Facility Based Habilitation and Adult Day Services

Service Standards

- Transportation service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.
- Transportation services under the waiver shall be offered in accordance with the Individualized Support Plan (ISP), and when unpaid transportation is not available.
- Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Documentation Standards

Service Notes: A service note can include multiple discrete services as long as discrete services are clearly identified. A service note entry for this service can be part of a comprehensive daily note with other services recorded, as long it is clearly separated from other services in the note.

A service note must include:

- Consumer name

- RID #
- Date of Service
- Provider rendering service
- Pick up point and destination
- If contract transportation is utilized, contractor must provide log and invoice support that includes date(s) of transportation provided.
- If bus passes or alternative methods of transportation are utilized, invoices and attendance logs must support days for which round trips are billed to the waiver.

Limitations

Activities Not Allowed

- May not be used to meet medical transportation needs already available under the Indiana Medicaid State Plan

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available under the Family Supports Waiver.
- There is no prohibition against using Transportation services to get to or from a place of employment providing this is reflected in the ISP
- Transportation may be used to reach any non-medical destination or activity outlined within the ISP

Section 10.29B: Transportation (as specified in the Community Integration and Habilitation Waiver)

Transportation

Service Definition

Transportation Services enable waiver participants under the Community Integration and Habilitation Waiver to gain access to any non-medical community services, resources/destinations or places of employment, maintain or improve their mobility within the community, increase independence and community participation and prevent institutionalization as specified by the Individualized Support Plan and plan of care.

SPECIFIC TO THE COMMUNITY INTEGRATION AND HABILITATION WAIVER ONLY: Depending upon the needs of the participant, there are three levels of transportation. The level of transportation service needed must be documented in the ISP.

- *Level 1: Transportation in a private, commercial, or public transit vehicle that is not specially equipped.*
- *Level 2: Transportation in a private, commercial, or public transit vehicle specially designed to accommodate wheelchairs.*
- *Level 3: Transportation in a vehicle specially designed to accommodate a participant who for medical reasons must remain prone during transportation (e.g. ambulette).*

Reimbursable Activities

- Two one-way trips per day to or from a non-medical community service or resource as specified on the ISP and provided by an approved provider of Residential Habilitation and Support, Community Based Habilitation, Facility Based Habilitation, Adult Day Services or Transportation Services.
- Bus passes or alternate methods of transportation may be utilized for Level 1 or Level 2. Bus passes may be purchased on a monthly basis or on a per-ride basis, whichever is most cost effective in meeting the participant's transportation needs as outlined in the ISP
- May be used in conjunction with other services, including Community Based Habilitation, Facility Based Habilitation and Adult Day Services
- NOTE: Whenever possible, family, neighbors, friends or community agencies, which can provide Transportation Services without charge will be utilized.

Service Standards

- Transportation service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.
- Transportation services under the waiver shall be offered in accordance with the Individualized Support Plan (ISP), and when unpaid transportation is not available.
- Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Documentation Standards

Service Notes: A service note can include multiple discrete services as long as discrete services are clearly identified. A service note entry for this service can be part of a comprehensive daily note with other services recorded, as long it is clearly separated from other services in the note.

A service note must include:

- Consumer name
- RID #
- Date of Service
- Provider rendering service
- Pick up point and destination
- If contract transportation is utilized, contractor must provide log and invoice support that includes date(s) of transportation provided.
- If bus passes or alternative methods of transportation are utilized, invoices and attendance logs must support days for which round trips are billed to the waiver.

Limitations

Annual limits have been added to this non-medical waiver Transportation service, the costs of which have been removed from the Day Services Building Block of the annual allocation for each participant and are now paid from a stand-alone but limited bucket outside of and in addition to the participants' annual allocation amount. Note that no participant is excluded from participating in non-medical waiver Transportation services.

The annual limits for each level of non-medical waiver Transportation are:

- $2500 for Level 1 Transportation
- $5000 for Level 2 Transportation
- $7500 for Level 3 Transportation

Activities Not Allowed

- May not be used to meet medical transportation needs already available under the Indiana Medicaid State Plan
- May not be used in conjunction with Structured Family Caregiving services

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available under Community Integration and Habilitation Waiver.
- There is no prohibition against using Transportation services to get to or from a place of employment providing this is reflected in the ISP
- Transportation may be used to reach any non-medical destination or activity outlined within the ISP

Section 10.30: Workplace Assistance

Workplace Assistance

Service Definition

Workplace Assistance Services provide a range of personal care services and/or supports during paid competitive community employment hours and in a competitive community employment setting to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a personal care task for the participant) or cuing to prompt the participant to perform a personal care task. Workplace Assistance services may be provided on an episodic or on a continuous basis.

Workplace Assistance Services are services that are designed to ensure the health, safety and welfare of the participant, thereby assisting in the retention of paid employment for the participant who is paid at or above the federal minimum wage.

Reimbursable Activities

- Direct supervision, monitoring, training, education, demonstration or support to assist with personal care while on the job or at the job cite (may included assistance with meals, hygiene, toileting, transferring, maintaining continence, administration of medication, etc.)
- May be used in conjunction with Supported Employment Follow-Along services
- May be utilized with each hour the participant is engaged in paid competitive community employment

Service Standards

- Workplace Assistance Services must be reflected in the Individualized Support Plan (ISP)
- Workplace Assistance Services should complement but not duplicate community habilitation services being provided in other settings
- Workplace Assistance Services may only be delivered in the employment setting. There is no requirement for a physician's prescription or authorization. The need for Workplace Assistance Services is determined entirely by the Individualized Support Team.

Documentation Standards

- Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

Limitations

- Allowed Ratio - Individual, 1:1
- Reimbursement for Workplace Assistance Services is available only during the participant's hours of paid, competitive community employment
- Workplace Assistance is NOT to be used for observation or supervision of the participant for the purpose of teaching job tasks or to ascertain the success of the job placement

- Workplace Assistance is NOT to be used for offsite monitoring when the monitoring directly relates to maintaining a job
- Workplace Assistance is NOT to be used for the provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment
- Workplace Assistance is NOT to be used for regular contact and/or follow-up with the employers, participants, parents, family members, guardians, advocates or authorized representatives of the participants, or other appropriate professional or informed advisors, in order to reinforce and stabilize the job placement
- Workplace Assistance is NOT to be used for the facilitation of natural supports at the work site
- Workplace Assistance is NOT to be used for Individual program development, writing tasks analyses, monthly reviews, termination reviews or behavioral intervention programs
- Workplace Assistance is NOT to be used for advocating for the participant
- Workplace Assistance is NOT to be used for staff time in traveling to and from a work site.

Activities Not Allowed

Reimbursement is not available through Workplace Assistance Services under the following circumstances:

- When services are furnished to a minor child by the parent(s) or step-parent(s) or legal guardian
- When services are furnished to a participant by that participant's spouse
- Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142
- During volunteer activities
- In a facility setting
- In conjunction with sheltered employment
- During activities other than paid competitive community employment
- Workplace Assistance should complement but not duplicate services being provided under Supported Employment Follow Along services

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.
- May be used in conjunction with Supported Employment Follow-Along (SEFA) services
- May be utilized with each hour the participant is engaged in paid competitive community employment, including employment hours overlapping with SEFA

Section 10.31: Case Management

SERVICE DEFINITION:

Case Management Services means services that enable a participant to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner. Case management assists participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case Management Services must be reflected in the Individual Support Plan (ISP) and must address needs identified in the person centered planning process.

Reimbursable Activities:

- Developing, updating, and reviewing the Individualized Support Plan (ISP) using the Person Centered Planning Process.
- Convening team meetings quarterly and as needed to discuss the ISP and any other issues needing consideration in relation to the participant.
- Completion of a DDRS-approved health and safety indicator assessment tool during service plan development, initially, annually and when there is a change in the participant's status.
- Monitoring of service delivery and utilization (via telephone calls, home visits and team meetings) to ensure that services are being delivered in accordance with the ISP.
- Completing and processing the annual Level of Care determination.
- Compiling case notes for each encounter with the participant.
- Conducting face-to-face contacts with the individual (and family members, as appropriate) at least once each quarter in the home of the waiver participant and as needed to ensure health and welfare and to address any reported problems or concerns.
- Completing and processing the 90-Day Checklist.
- Developing initial, annual and update Cost Comparison Budgets using the State approved process.
- Disseminating information including all Notices of Action and forms to the participant and the Individualized Support Team (IST).

- Completing, submitting and following up on incident reports in a timely fashion using the State-approved process, including notifying the family/guardian of the incident outcome, all of which must be verifiable by documented supervisory oversight and monitoring of the Case Management agency.
- Monitoring participants' health and welfare.
- Monitoring participants' satisfaction and service outcomes.
- Monitoring claims reimbursed through the approved Medicaid Management Information System (MMIS) and pertaining to waiver-funded services.
- Maintaining files in accordance with State standards.
- Cultivating and strengthening informal and natural supports for each participant.
- Identifying resources and negotiating the best solutions to meet identified needs.

ACTIVITIES NOT ALLOWED:

The case management agency may not own or operate another waiver service agency, nor may the case management agency be an approved provider of any other waiver service.

Reimbursement is not available through Case Management Services for the following activities or any other activities that do not fall under the definition listed above:

- Services delivered to persons who do not meet eligibility requirements established by BDDS.
- Counseling services related to legal issues. Such issues shall be directed to the Indiana Advocacy Services, the designated Protection and Advocacy agency under the Developmental Disabilities Act and Bill of Rights Act, P.L. 100-146.
- Case Management conducted by a person related through blood or marriage to any degree to the waiver participant.

SERVICE STANDARDS:

Case managers must understand, maintain and assert that the Medicaid program functions as the payer of last resort. The role of the case manager includes care planning, service monitoring, working to cultivate and strengthen informal and natural supports for each

participant, and identifying resources and negotiating the best solutions to meet identified needs. Toward these ends, case managers are required to:

- Demonstrate a willingness and commitment to explore, pursue, access and maximize the full array of non-waiver-funded services, supports, resources and unique opportunities available within the participant's local community, thereby enabling the Medicaid program to complement other programs or resources.
- Be a trained facilitator who has completed a training provided by a Division of Disability and Rehabilitative Services (DDRS)/Bureau of Developmental Disabilities Services (BDDS)-approved training entity or person; observed a facilitation; and participated in a person centered planning meeting prior to leading an Individualized Support Team (IST)
- Participate in developing, updating, and reviewing the Individualized Support Plan (ISP) using the Person Centered Planning Process, including development of a person-centered description that is used as the basis for care planning.
- Monitor participant outcomes using a State-approved standardized tool.
- Convene team meetings at least quarterly and as needed.
- Complete and process the annual Level of Care determination within specified timeframes.
- Maintain case notes for each participant on no less than a monthly basis.
- Complete the DDRS-approved health and safety indicator assessment tool during initial assessment, annually and any time there is a change in the participant's status.
- Monitor service delivery and utilization (via telephone calls, home visits and team meetings) to ensure that services are being delivered in accordance with the ISP.
- Conduct face-to-face contacts with the individual (and family members, as appropriate) in at least once each quarter the home of the participant and as needed to ensure health and welfare and to address any reported problems or concerns.
- Complete and process the 90-Day Checklist in a timely fashion. (Completion must be face-to-face)
- Develop the annual Cost Comparison Budgets using the State-approved process.
- Develop update Cost Comparison Budgets, as needed, using the State-approved process.

- Disseminate information, including all Notices of Action and forms, to the participant and the Individualized Support Team (IST) within specified timeframes.
- Complete, submit and follow up on incident reports in a timely fashion using the State-approved process, including notifying the family/guardian of the incident outcome, all of which must be verifiable by documented supervisory oversight and monitoring of the Case Management agency
- Monitor participants' health and welfare.
- Monitor participants' satisfaction and service outcomes.
- Monitor claims submitted through the approved Medicaid Management Information System (MMIS) and pertaining to waiver-funded services.

At minimum, the Case Management agency must provide a 60 day notice to the participant (and to his or her legal guardian, if applicable) prior to the termination of Case Management services.

Upon request of the participant and/or his or her legal guardian, if applicable, the participant's most recently selected Case Management agency must provide a pick list of alternate DDRS-approved Case Management provider agencies and assist the participant in selecting a new provider of Case Management.

Noting the participants' have right to select and transition to a new provider of Case Management services at any time, only one Case Management provider agency may bill for the authorized monthly unit of Case Management services during any given month. With the state's approval of the participant's Plan of Care/Cost Comparison Budget (CCB), a single prior authorization of the monthly Case Management service unit will be sent from the operating agency (DDRS) to the contractor of the Medicaid Management Information System (MMIS). Therefore, it is *recommended* that transitions from one Case Management agency to another occur on the first day of the month. When transitions occur on other days of the month, the two providers of Case Management services must determine which provider agency will bill and whether or not one agency owes the other a portion of the monthly fee. Providers will handle any such transactions and/or arrangements amongst themselves, with both (or all) provider agencies being held responsible for documenting these transactions in regard to future financial audits.

Documentation Standards

- The weekly case note requirement has been waived until further notice. However, case managers must perform and document one meaningful activity on behalf of the individual waiver participant each calendar month.

- Preferred practice calls for activity to be documented via case note within 48 hours of a case management activity or event. At a minimum, a case note must be completed within seven days of an activity or event.

PROVIDER QUALIFICATIONS

Case management agencies must:

- Be enrolled as an active Medicaid provider
- Must be DDRS Approved
- Must comply with Indiana Administrative Code, 460 IAC 6

- Must comply with the Case Management Service Checklist as well as any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual

- Be bonded thru Surety Bonding

- Carry professional liability insurance on all case managers hired by the agency

- Employ at least one full-time Registered Nurse

- Retain at least two full-time, certified Case Managers within the organizational structure in order to submit an application and receive approval as a DDRS-approved provider of Case Management services

- Require initially and annually, that each case manager employed by the DDRS-approved Case Management agency obtain certification/proof of competency demonstrated thru successful completion of the DDRS/BBDS-approved case management training curriculum, attaining of a test score no lower than 95%

- Ensure, ongoing, that criminal background checks are conducted for every employee/partner hired or associated with the approved Case Management provider agency

- Retain at least one full time compliance officer to actively monitor all areas of compliance
- Be approved by DDRS and in ongoing compliance with any applicable BDDS service standards, guidelines, policies and/or manuals, including minimum qualifications of case managers. Case Management minimum qualifications state that all case managers providing services must comply with one or more of the qualifications set forth below:

  1. Holding a bachelor's degree in one of the following specialties from an accredited college or university:

     a) Social work
     b) Psychology
     c) Sociology
     d) Counseling
     e) Gerontology
     f) Nursing
     g) Special education
     h) Rehabilitation
     i) or related degree if approved by DDRS/OMPP representative

  2. Being a registered nurse with one (1) year experience in human services.

  3. Holding a bachelor's degree in any field with a minimum of one (1) year full-time, direct experience working with persons with intellectual/developmental disabilities.

  4. Holding a master's degree in a related field may substitute for required experience.

  Additionally, the case manager must meet the requirements for a qualified mental retardation professional in 42 CFR 483.430(a)

- Provide and maintain a 24/7 emergency response system that does not rely upon the area 911 system and provides assistance to all waiver participants. The 24/7 line staff must assist participants or their families with addressing immediate needs and contact the participant's case manager to ensure arrangements are made to address the immediate situation and to prevent reoccurrences of the situation.
- Maintain sufficient technological capability to submit required data electronically in a format and through mechanisms specified by the State.
- Electronically enter all case information at the frequency specified by the Division
- Ensure each Case Manager is properly equipped to conduct onsite processing (has a laptop computer and portable printer)

- Ensure each Case Manager is properly equipped to conduct two-way mobile communications and is accessible as needed to the participants he or she serves (has a cell phone, I phone or other similar equipment)
- Maintain a sufficient number (no fewer than two) of qualified Case Managers in the approved service area.
- Ensure that case managers are trained in the Person-Centered Planning Process and in the development of person-centered descriptions.
- Ensure that Case Managers meet with their participants on a regular basis to develop and support the execution of individualized service plans.
- Have a mechanism for monitoring the quality of services delivered by case managers and reporting on and addressing any quality issues that are discovered.
- All DDRS-approved Case Management agencies specifically agree to comply with the provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et seq*. and 47 U.S.C. 225).
- Have the capability to effectively and efficiently communicate with each participant by whatever means is preferred by the participant, including accommodating participants with Limited English Proficiency (LEP).
- Be accredited by at least one (1) of the following organizations:
  (1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
  (2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
  (3) The Council on Accreditation;
  (4) An independent national accreditation organization approved by the Secretary of FSSA.

  Application for a survey through the accrediting entity for a new service must be submitted within one year of receiving approval.

  The agency must submit to the Bureau of Developmental Disabilities Services proof of application for an accreditation survey, and a copy of the letter from the accrediting entity indicating accreditation for a one (1) to three (3) year period.

In addition, Indiana maintains a conflict-free case management policy. This covers conflict of interest in terms of provision of services as well as in relationship to the participant being served. Conflict-free means:

- Case Management agencies may not be an approved provider of any other waiver service.
- The owner(s) of one Case Management agency may not own multiple Case Management agencies
- The owner(s) of one Case Management agency may not be a stakeholder of any other waiver service agency
- There may be no financial relationship between the referring Case Management agency, its staff and the provider of other waiver services.
- In addition, case managers must not be:
    - related by blood or marriage to the participant,
    - related by blood or marriage to any paid caregiver of the participant,
    - financially responsible for the participant, or
    - authorized to make financial or health-related decisions on behalf of the participant.

Additional Information:

- Case Management services are required under both the Family Supports Waiver and the Community Integration and Habilitation Waiver

Section 10.32: Participant Assistance and Care

Participant Assistance and Care

Service Definition

Participant Assistance and Care (PAC) Services are provided in order to allow participants (consumers) with intellectual/developmental disabilities to remain and live successfully in their own homes, function and participate in their communities and avoid institutionalization. PAC services support and enable the participant in activities of daily living, self-care, and mobility with the hands-on assistance, prompting, reminders, supervision and monitoring needed to ensure the health, safety and welfare of the participant.

Reimbursable Activities

Activities may include any task or tasks of direct benefit to the participant that would generally be performed independently by persons without intellectual/developmental disabilities or by family members for or on behalf of persons with intellectual/developmental disabilities.

Examples of activities include but are not limited to the following:

- Assistance with personal care, meals, shopping, errands, scheduling appointments, chores and leisure activities (excluding the provision of transportation)
- Assistance with mobility – including but not limited to transfers, ambulation, use of assistive devices
- Assistance with correspondence and bill paying
- Escorting the participant to community activities and appointments
- Supervision and monitoring of the participant
- Reinforcement of behavioral support
- Adherence to risk plans
- Reinforcement of principle of health and safety
- Completion of task list

Participating on the Individualized Support Team (IST) for the development or revision of the service plan (staff must attend the IST meeting in order to claim reimbursement)

Service Standards

- Participant Assistance and Care (PAC) services must follow a written Plan of Care addressing the specific needs determined by the participant's assessment and indentified in the Individualized Support Plan (ISP)

- Ability to consult with a nurse as needed (on staff or on call for the provider)

Documentation Standards

- Recorded completion of tasks on a participant-specific Task List (created by the Individualized Support Team) which includes identification of the paid staff member(s) as well as the date and start/stop time of each waiver-funded shift.

- Documentation in compliance with 460 IAC 6

Limitations

- Parents, step-parents and legal guardians may not be paid to provide care to **minor** children while other relatives* or groups of relatives may provide a combined total of up to 40 hours per week in PAC services to a **minor** child.
- Spouses may not provide paid services at all, while reimbursable waiver funded Participant Assistance and Care (PAC) services furnished to an **adult** waiver participant by any combination of relative(s)* and/or legal guardian(s) may not exceed a combined total of 40 hours per week.

* Related/relative implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:

1) Aunt (natural, step, adopted)
2) Brother (natural, step, half, adopted, in-law)
3) Child (natural, step, adopted)
4) First cousin (natural, step, adopted)
5) Grandchild (natural, step, adopted)
6) Grandparent (natural, step, adopted)
7) Nephew (natural, step, adopted)
8) Niece (natural, step, adopted)
9) Parent (natural, step, adopted, in-law)
10) Sister (natural, step, half, adopted, in-law)
11) Spouse (husband or wife)
12) Uncle (natural, step, adopted)

Activities Not Allowed

- Participant Assistance and Care (PAC) services will not be provided to household members other than to the waiver participant(s)

- Reimbursement is <u>not</u> available through Participant Assistance and Care (PAC) in the following circumstances:

- When services are furnished to a **minor** by the parent(s), step-parent(s), or legal guardian
- When services are furnished to a participant by the participant's spouse
- When services furnished to a minor by relatives* other than parent(s), step-parent(s) or legal guardians exceed a combined total of 40 hours per week
- When services furnished to an adult by any combination of relatives* exceed a combined total of 40 hours per week
- When Indiana Medicaid State Plan services are available for the same task(s)
- When services provided are available under the Rehabilitation Act of 1973 or section 602(16) & (17) of Individual with Disabilities Education Act
- Homeschooling, special education and related activities
- When the participant is admitted to an institutional facility (e.g., Acute Hospital, Nursing Facility, ICF/ID)
- For homemaker or maid service
- As a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, behaviorist, licensed therapist or other health professional.
- Excludes transportation

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Participants will utilize any appropriate services available under the Indiana Medicaid State Plan
- Utilization of PAC services does not prohibit the use of any other service available under the Family Supports Waiver that is outlined on the Individualized Support Plan (ISP)

Section 10.33: Structured Family Caregiving

Structured Family Caregiving

Service Definition

Structured Family Caregiving means a living arrangement in which a participant lives in the private home of a principal caregiver who may be a non-family member (foster care) or a family member who is not the participant's spouse, the parent of the participant who is a minor, or the legal guardian of the participant.

Necessary support services are provided by the principal caregiver (family caregiver) as part of Structured Family Caregiving. Only agencies may be Structured Family Caregiving providers, with the Structured Family Caregiving settings being approved, supervised, trained, and paid by the approved agency provider. The provider agency must conduct two visits per month to the home – one by a registered nurse and one by a Structured Family Caregiving Home Manager. The provider agency must keep weekly notes that can be accessed by the state. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Structured Family Caregiving, since these services are integral to and inherent in the provision of Structured Family Caregiving services.

Service Levels and Rates

There are three service levels of Structured Family Caregiving (SFC), each with a unique rate. Beginning January 1, 2013, the Algo level assigned to the participant will drive and determine the appropriate level of SFC service and reimbursement to be utilized in service plan development at the participant's next annual anniversary date. With the phase in of this methodology, all participants will be served at or above their pre-existing level of SFC service.

- Level 1 – Appropriate for participants choosing SFC and having an Algo level of 0 or 1
- Level 2 – Appropriate for participants choosing SFC and having an Algo level of 2
- Level 3 – Appropriate for participants choosing SFC and having an Algo level of 3, 4, 5 or 6

Reimbursable Activities

- Personal care and services
- Homemaker or chore services
- Attendant care and companion care services

• Medication oversight

• Respite for the family caregiver (funding for this respite is included in the per diem paid to the service provider, the actual service of Respite Care may not be billed in addition to the per diem)

• Other appropriate supports as described in the Individualized Support Plan

Service Standards

• Structured Family Caregiving services must be reflected in the Individualized Support Plan

• Services must address the needs (for example, intellectual/developmental needs, vocational needs, and so forth) identified in the person centered planning process and be outlined in the Individualized Support Plan

• 10% of the total per diem amount is intended for use by the provider for respite care as needed. It is the provider's responsibility to approve any providers of respite chosen by the family or the participant

• The provider determines the total amount per month paid to the family caregiver

• The agency's administrative/supervision fee comes from the remaining total amount and includes the following duties:

1) Publish written policies and procedures regarding Structured Family Caregiver support services;
2) Maintain financial and service records to document services provided to the individual;
3) Establish a criteria for the acceptance of the family caregiver or foster parent, screen potential family caregivers/foster parents for qualities of stability, maturity, and experiences so as to ensure the safety and well being of the individual, and obtain a criminal background and reference check;
4) Coordinate/provide adequate initial training and ongoing training, consultation and supervision to the family caregiver/foster parent;
5) Provide for the safety and well being of the participant by inspection of environment for compliance with DDRS policies and procedures, including, but not limited to, the provider and case management standards found in 460 IAC 6 Supported Living Services and Supports requirements; and
6) Reimburse family caregiver/foster parent.

Documentation Standards

- Written policies and procedures, including for screening and accepting family caregivers/foster parents.
- Maintain financial and service records to document services provided to the participant.
- Document provision of training to family caregivers according to agency policies/procedures.
- Reimbursement of family caregiver/foster parent.
- One entry per participant per week

Documentation by Families:

- One dated entry per day detailing an issue concerning the participant
- The entry should detail any outcome-oriented activities, tying those into measurable progress toward the participant's outcome (as identified in the ISP)
- The entry should also include any significant issues concerning the individual, including:
    - o Health and safety management
    - o Intellectual/developmental challenges and experiences aimed at increasing an participant's ability to live a lifestyle that is compatible with the participant's interest and abilities
    - o Modification or improvement of functional skills
    - o Guidance and direction for social/emotional support
    - o Facilitation of both the physical and social integration of an participant into typical family routines and rhythms

Limitations

Activities Not Allowed

• Services provided by a caregiver who is the spouse, parent of the minor participant or legal guardian to the participant

• The service of Residential Habilitation and Supports is not available to participants receiving the service of Structured Family Caregiving Services.

• Transportation services through the waiver may not be used in conjunction with Structured Family Caregiving Services.

Provider Qualifications

- Enrolled as an active Medicaid provider
- Must be DDRS-approved
- Must comply with Indiana Administrative Code, 460 IAC 6
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Additional Information:

- Available only under the Community Integration and Habilitation Waiver. Structured Family Caregiving is not available under the Family Supports Waiver.